COUNTY OF LOS ANGELES
Public Health

JONATHAN E. FIELDING, M.D., M.P.H.
Director and Health Officer

JONATHAN E. FREEDMAN
Chief Deputy Director

313 North Figueroa Street, Room 806
Los Angeles, California 90012
TEL (213) 240-8117 • FAX (213) 975-1273

www.publichealth.lacounty.gov



February 16, 2010

ADOPTED
BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

25 FEBRUARY 16, 2010

Sachi A. Hamai
SACHI A. HAMAI
EXECUTIVE OFFICER

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

**APPROVAL OF 44 HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME CARE SERVICE AMENDMENTS (ALL SUPERVISORIAL DISTRICTS)(3 VOTES)**

**SUBJECT**

Approval to amend 44 Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome care service agreements for the Office of AIDS Programs and Policy, to extend the terms and revise funding allocations.

**IT IS RECOMMENDED THAT YOUR BOARD**

1. Delegate authority to the Director of the Department of Public Health (DPH), or his designee, to execute amendments, substantially similar to Exhibit I, to 43 Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) service agreements that either maintain status quo or increase agreement maximum obligations pursuant to the DPH Office of AIDS Programs and Policy's (OAPP's) implementation of the Commission on HIV's funding allocations, for a total maximum obligation of $14,988,065 (the current total maximum obligation of these agreements is $9,457,426), funded by State and federal funds and net County cost (NCC), and to extend the terms as follows: a) effective March 1, 2010 through February 28, 2011 for four adult residential facilities and residential care facilities for the chronically ill services; and b) effective March 1, 2010 through February 29, 2012 for 39 food bank/home-delivered meals/nutritional supplements; mental health, psychotherapy; substance abuse day treatment; substance abuse residential rehabilitation; substance abuse residential detoxification; and substance abuse transitional housing services, as indicated in Attachment A.

2. Authorize the Director of DPH, or his designee, to execute an amendment to Agreement

Number H-204756 with the USC School of Dentistry for the provision of oral health services to increase the agreement maximum obligation from $175,060 to $399,072, from the date of Board approval through February 28, 2011.

3. Delegate authority to the Director of DPH, or his designee, to execute amendments to the 44 agreements, to rollover any unspent funds, and increase or decrease each contract maximum obligation up to 30 percent, funded by State and federal funds, subject to review and approval by County Counsel and the Chief Executive Office and notification to your Board.

## PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Your Board's approval of the 44 amendments will allow DPH to extend or increase the amount of service provided under the agreements, allowing OAPP to immediately utilize a portion of the Ryan White Program (RWP) Part A funding award for Year 20, thereby ensuring continuation of critical HIV/AIDS services countywide. This strategy is necessary to maintain a stable system of care and treatment for HIV-infected individuals, and will also allow expansion of endodontic oral health care services (highly specialized oral healthcare services, including root canal therapy) provided by the USC School of Dentistry, on an immediate basis, enhancing the oral healthcare capacity of the RWP system in historically underserved communities in Los Angeles County (County).

Under this recommended Board action, the agreement with the USC School of Dentistry is being amended to increase its maximum obligation above OAPP's delegated authority, to allow for the expansion of endodontic oral healthcare services through February 28, 2011, fully offset by RWP Part A funds.

Acceptance of a 30 percent increase or decrease of each agreement's maximum obligation under DPH's delegated authority will allow immediate response by DPH to any State or federal funding changes, especially reductions to the HIV/AIDS portfolio which may impact providers in the County, as a result of the State budget crisis, or to adjustments to RWP Part A funding, effective March 1, 2010. In addition, agreement provisions will allow DPH to reallocate funding between providers based upon on-going analysis of service utilization and grant expenditures to ensure that grant funds are maximized and clients continue to receive much-needed services.

Existing County policy and procedure require timely submission of agreements for Board approval. This Board action was not scheduled for placement on the Board's agenda three weeks prior to its effective date as required due to delays by OAPP in completing the final agreement allocations, a process complicated by OAPP's recent significant staff reductions and on-going uncertainty regarding State funding as a result of the governor's final 2009-10 budget actions.

## Implementation of Strategic Plan Goals

These recommended Board actions support Goal 3, Community Services, and Goal 4, Health and Mental Health, of the County Strategic Plan, by supporting community-based HIV/AIDS services and programs for Los Angeles County residents.

## FISCAL IMPACT/FINANCING

The total program cost for these services is $15,387,137 consisting of $7,999,608 in RWP Part A funds; $977,512 in Centers for Substance Abuse and Treatment funds; $474,999 in Third Supervisorial District funds; $1,533,232 in Single Allocation Model (SAM) Care funding from the California Office of AIDS (OA); and $4,401,786 in existing NCC funds.

Funding for this action is included in DPH's Fiscal Year (FY) 2009-10 Final Adopted Budget and will be included in future FYs, as necessary.

## FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Annually, the County Eligible Metropolitan Area (EMA) receives a RWP Part A award. For Year 19, which ends February 28, 2010, the total EMA RWP Part A award totaled $35,910,442, an increase of nearly $2.5 million over the prior year. For RWP Year 20 which begins March 1, 2010, the Minority AIDS Initiative (MAI), will be realigned with the RWP Part A grant year and begin March 2010, resulting in increased revenue in the approximate amount of $1 million for the March to July 2010, five-month period. Notification of the formula-based portion of the award is generally received on or before March 1 of the grant year. Notification of the competitive supplemental portion of the award follows within 60 days. Therefore, the exact amount of the Year 20 award is unknown at this time, however, in addition to the service modalities indicated in Attachment A, funding will also be allocated to the other care and treatment services, such as: medical outpatient; transportation; medical case management; case management, psychosocial; food bank/nutrition; and mental health, psychotherapy.

The RWP authorizes grants for the development, coordination, and operation of effective and cost-efficient services for persons living with HIV/AIDS. The RWP allows the County to receive both RWP Part A and MAI funds. As a result of the State budget reductions, the California OA reorganized and concentrated its programs and funding distribution process and now allocates funding to the County EMA through a SAM. SAM "Care" funds combine funding from Health Resources and Services Administration and other federal partners into a simplified distribution plan for the County.

Modifications to the "Billing and Payment" paragraphs have been included in the proposed amendments to align with the most recent County-approved language. This Board action includes fee-for-service, cost reimbursement, and payment for performance agreements.

Exhibit I has been approved as to form by County Counsel. Attachment A provides additional information.

## CONTRACTING PROCESS

The Ryan White Program, enacted in 1990, has been invested to support a broad range of care and support services to the County since 1992. Leading into Year 20, these 44 agreements have undergone multiple amendments since their original award dates, some of which include: term extensions, adjustments to funding allocations, and revisions to their scopes of work.

On February 19, 2008, your Board's approval to extend the term of 85 agreements for the continued provision of HIV/AIDS care services in Year 18 extended the term of: 1) 54

agreements for the period of March 1, 2008 through February 28, 2010, for a total maximum obligation of $22,692,330; and 2) 31 agreements for the period of March 1, 2008 through February 28, 2009, for a total maximum obligation of $5,214,932.

Of the 54 agreements expiring on February 28, 2010, referenced above, 43 are being requested for extension under this Board action. Additionally, of the 31 agreements referenced above that were further approved for amendment by your Board on February 24, 2009 and May 26, 2009, to extend the term of the agreements through February 28, 2011, one agreement (USC School of Dentistry, Agreement Number H-204756) is being amended under this Board action to increase the maximum obligation above the Board-approved delegated authority amount, for a total of 44 amendments. The remaining 41 agreements (11 of 54; and 30 of 31) referenced in the paragraph above will not be amended under this Board action for the following reasons: 1) 19 agreements were terminated as a result of the September 15, 2009 Board Memo reducing or eliminating contract obligations; 2) one agreement was terminated on March 31, 2009, as a result of poor contract performance; 3) 11 agreements will sunset on February 28, 2010 and will not be renewed as a result of State budget reductions; and 4) Under DPH's delegated authority approved by your Board on May 26, 2009, ten agreements from Year 19 are being extended through February 28, 2011, and therefore, are not being amended under this Board action.

OAPP is currently finalizing two Request for Proposals, both targeted for release in February 2010: 1) for Medical Outpatient and Medical Specialty Services; and 2) for Residential Care Services (which will include Residential Care Facility for the Chronically Ill, Residential Care Facility for the Transitioning or Moderately Ill, Skilled Nursing Facility, and Residential Hospice Facility).

**IMPACT ON CURRENT SERVICES (OR PROJECTS)**

Approval of these actions will allow DPH to continue to provide uninterrupted delivery of HIV/AIDS care to Los Angeles County residents.

Respectfully submitted,

Jonathan E. Fielding, M.D., M.P.H.
Director and Health Officer

JEF:ly
#01392

Attachments (2)

c: Chief Executive Officer
Acting County Counsel
Executive Officer, Board of Supervisors

Exhibit I

Contract No. H-_____

**HUMAN IMMUNODEFICIENCY VIRUS (HIV)/**
**ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)**
**{ENTER SERVICE CATEGORY} SERVICES**

Amendment Number _____

THIS AMENDMENT is made and entered into this _____ day of _____, 2010,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and _____ (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "HUMAN IMMUNODEFICIENCY VIRUS (HIV)/ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) {ENTER SERVICE CATEGORY} SERVICES AGREEMENT", dated _____, and further identified as Agreement Number _____, and any Amendments thereto (all hereafter "Agreement"); and

WHEREAS, it is the intent of the parties hereto to extend Agreement and provide other changes set forth herein; and

WHEREAS, said Agreement provides that changes may be made in the form of a written Amendment which is formally approved and executed by the parties.

WHEREAS, this Agreement is therefore authorized under Section 44.7 of the Los Angeles County Charter and Los Angeles County Codes Section 2.121.250; and

WHEREAS, County is authorized by Government Code Section 31000 to contract for these services.

NOW, THEREFORE, the parties hereto agree as follows:

1. This Amendment shall be effective on March 1, 2010.

2. The first and third paragraphs of Paragraph 1, TERM, shall be amended to read as follows:

"1. TERM: The term of this Agreement shall commence on _____, and continue in full force and effect through February 28, 2012, subject to the availability of federal, State, or County funding sources. In any event, County may terminate this Agreement in accordance with the TERMINATION Paragraphs of the ADDITIONAL PROVISIONS hereunder."

"County shall not be obligated for Contractor's performance hereunder or by any provision of this Agreement during any of County's fiscal years (July 1 - June 30) unless and until County's Board of Supervisors appropriates funds for this Agreement in County's Budget for each fiscal year. If County's Board of Supervisors fails to appropriate funds for any fiscal year, this Agreement shall be deemed to have terminated June 30th of the prior fiscal year. County shall notify Contractor in writing of such non-allocation of funds at the earliest possible date. If for any reason any funding which funds this Agreement is terminated or reduced, County shall have the right to immediately terminate this Agreement in whole or in part. Notice of such termination shall be served upon Contractor in writing."

3. Paragraph 2, DESCRIPTION OF SERVICES, shall be amended to read as follows:

"2. DESCRIPTION OF SERVICES: Contractor shall provide the services described in Exhibit(s) __ attached hereto and incorporated herein by reference."

4. Paragraph 3, MAXIMUM OBLIGATION OF COUNTY, Subparagraph ____, shall be added to Agreement as follows:

"__. During the period March 1, 2010 through February 28, 2011, maximum obligation of County for all services provided hereunder shall not exceed _____ Dollars ($_____).

Such maximum obligation is comprised entirely of Ryan White Program, Part A funds. This sum represents the total maximum obligation of County as shown in Schedule(s) ___, attached hereto and incorporated herein by reference.

__. During the period March 1, 2011 through February 28, 2012, maximum obligation of County for all services provided hereunder shall not exceed _____Dollars ($_____).

Such maximum obligation is comprised entirely of Ryan White Program, Part A funds. This sum represents the total maximum obligation of County as shown in Schedule(s) ___, attached hereto and incorporated herein by reference."

5. Paragraph 4, FUNDING/SERVICES ADJUSTMENTS AND REALLOCATIONS, shall be amended and replaced in its entirety to read as follows:

"4. FUNDING/SERVICES ADJUSTMENTS AND REALLOCATIONS:

A. If sufficient monies are available from Federal, State, or County funding sources, and upon Director's or his authorized designee's specific written approval, County may require additional services and pass on to Contractor an increase to the applicable County maximum obligation as payment for such services, as determined by County. For the purposes of this provision, Director's authorized designee shall be the Chief Deputy Director, Public Health or his designee. If monies are reduced by Federal, State, or County funding sources, County may also decrease the applicable County maximum obligation as determined by County. Such funding changes will not be retroactive, but will apply to future services following the provision of written notice from Director to Contractor. If such increase or decrease does not exceed twenty-five percent (25%) of the applicable County maximum obligation, Director may approve such funding changes. Director shall provide prior written notice of such funding changes to Contractor and to County's Chief Executive Officer. If the increase or decrease exceeds twenty-five percent (25%) of the applicable County maximum obligation, approval by County's Board of Supervisors shall be required. Any such change in any County maximum obligation shall be effected by an amendment to this Agreement pursuant to the ALTERATION OF TERMS Paragraph of this Agreement.

County and Contractor shall review Contractor's expenditures and commitments to utilize any funds, which are specified in this Agreement for the services hereunder and which are subject to time limitations as determined by

Director, midway through each County fiscal year during the term of this Agreement, midway through the applicable time limitation period for such funds if such period is less than a County fiscal year, and/or at any other time or times during each County fiscal year as determined by Director. At least fifteen (15) calendar days prior to each such review, Contractor shall provide Director with a current update of all of Contractor's expenditures and commitments of such funds during such County fiscal year or other applicable time period.

If County determines from reviewing Contractor's records of service delivery and billings to County that a significant underutilization of funds provided under this Agreement will occur over its term, Director or County's Board of Supervisors may reduce the applicable County maximum obligation for services provided hereunder and reallocate such funds to other providers. Director may reallocate a maximum of twenty-five percent (25%) of the applicable County maximum obligation or Two Hundred Thousand Dollars ($200,000), whichever is greater. Director shall provide written notice of such reallocation to Contractor and to County's Chief Executive Officer. Reallocation of funds in excess of the aforementioned amounts shall be approved by County's Board of Supervisors. Any such change in any County maximum obligation shall be effected by an amendment to this Agreement pursuant to the ALTERATION OF TERMS Paragraph of this Agreement.

B. Funds received under the Ryan White Program will not be utilized to make payments for any item or service to the extent that payment has been

made or can be reasonably expected to be made, with respect to any item or service by:

(1) Any State compensation program, insurance policy, or any federal, State, County, or municipal health or social service benefits program, or;

(2) Any entity that provides health services on a prepaid basis.

6. The following paragraph shall be added to the Agreement as follows: "NO PAYMENT FOR SERVICES PROVIDED FOLLOWING EXPIRATION/ TERMINATION OF AGREEMENT: Contractor shall have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any service provided by Contractor after the expiration or other termination of this Agreement. Should Contractor receive any such payment it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Agreement shall not constitute a waiver of County's right to recover such payment from Contractor. This provision shall survive the expiration or other termination of this Agreement."

7. Paragraph 6, COMPENSATION, shall be amended to read as follows:

"6. COMPENSATION: County agrees to compensate Contractor for performing services hereunder for actual reimbursable net cost as set forth in Schedule(s) {ENTER SCH #(s)}, and the BILLING AND PAYMENTS Paragraph of this Agreement. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets."

8. Paragraph ___, PAYMENTS, shall be amended to read as follows:

"__. BILLING AND PAYMENTS: Where applicable, County shall compensate Contractor services hereunder on a fee for service, cost reimbursement and/or payment for performance at the set fee-for-service rate(s), actual reimbursable net costs and/or any combination thereof incurred by Contractor in performing services hereunder.

A. Monthly Billing: Contractor shall bill County monthly in arrears. All billings shall include a financial invoice and all required programmatic reports and/or data. All billing shall clearly reflect all required information as specified on forms provided by County regarding the services for which claims are to be made and any and all payments made to Contractor by, or on behalf of, clients/patients. Billings shall be submitted to County within thirty (30) calendar days after the close of each calendar month. Within a reasonable period of time following receipt of a complete and correct monthly billing, County shall make payment in accordance with the Transitional Case Management actual reimbursable net cost schedule attached hereto.

(1) Payment for all services provided hereunder shall not exceed the aggregate maximum monthly payment set out in the schedule for the corresponding exhibit attached hereto.

(2) No single payment to Contractor for services provided hereunder shall exceed the maximum monthly payment set out in

the Schedule(s) for the corresponding Exhibit, unless prior approval from Director to exceed the maximum monthly payment has been granted pursuant to Paragraph _____of this Agreement. To the extent that there have been lesser payments for services under this Agreement, the resultant savings may be used to pay for prior or future monthly billings for services in excess of the maximum monthly payment in County's sole discretion.

(3) While payments shall be made in accordance with the fee-for-service rate(s) set out in the Schedule(s) hereto, Contractor, if requested by County, State, or federal representatives must be able to produce proof of actual costs incurred in the provision of units of services hereunder.

(4) If the actual costs are less than the fee-for-service rate(s) set out in the Schedule(s), Contractor shall be reimbursed for actual costs.

B. Audit Settlements:

(1) If an audit conducted by federal, State, and/or County representatives finds that units of service, actual reimbursable net costs for any services and/or combination thereof furnished hereunder are lower than units of service and/or reimbursement for stated actual net costs for any services for which payments were made to Contractor by County, then payment for the

unsubstantiated units of service and/or unsubstantiated reimbursement of stated actual net costs for any services shall be repaid by Contractor to County. For the purpose of this Paragraph ____, an "unsubstantiated unit of service" shall mean a unit of service for which Contractor is unable to adduce proof of performance of that unit of service and "unsubstantiated reimbursement of stated actual net costs" shall mean a stated actual net costs for which Contactor is unable to adduce proof of performance and/or receipt of the actual net cost for any service.

(2) If an audit conducted by federal, State, and/or County representatives finds that actual costs for a unit service provided hereunder are less than the County's payment than those units of service, then Contractor shall repay County the difference immediately upon request or County has the right to withhold and/or offset that repayment obligation against future payments.

(3) If within forty-five (45) calendar days of termination of the contract period, such audit finds that the units of service, allowable costs of services and/or any combination thereof furnished hereunder are higher than the units of service, allowable costs of services and/or payments made by County, then the difference may be paid to Contractor, not to exceed the County Maximum Obligation.

C. The parties acknowledge that County is the payor of last resort for services provided hereunder. Accordingly, in no event shall County be required to reimburse Contractor for those costs of services provided hereunder which are covered by revenue from or on behalf of clients/patients or which are covered by funding from other governmental contracts, agreements or grants.

D. In no event shall County be required to pay Contractor for units of services and/ or reimburse Contractor for those costs of services provided hereunder which are covered by revenue from or on behalf of clients/patients or which are covered by funding from other governmental contracts, agreements or grants.

E. In no event shall County be required to pay Contractor for units of services that are not supported by actual costs.

F. In the event that Contractor's actual cost for a unit of service are less than fee for service rates fee-for-service rate(s) set out in the schedule(s), the Contractor shall be reimbursed for its actual costs only.

G. In no event shall County be required to pay Contractor more for all services provided hereunder than the maximum obligation of County as set forth in the MAXIMUM OBLIGATION OF COUNTY Paragraph of this Agreement, unless otherwise revised or amended under the terms of this Agreement.

H. Travel shall be budgeted and expensed according to applicable federal, State, and/or local guidelines. Prior authorization, in writing, shall be required for travel outside Los Angeles County unless such expense is explicitly approved in the contract budget. Request for authorization shall be made in writing to Director and shall include the travel dates, locations, purpose/agenda, participants, and costs.

I. Withholding Payment:

(1) Subject to the reporting and data requirements of this Agreement and the Exhibit(s) attached hereto, County may withhold any claim for payment by Contractor if any report or data is not delivered by Contractor to County within the time limits of submission as set forth in this Agreement, or if such report, or data is incomplete in accordance with requirements set forth in this Agreement. This withholding may be invoked for the current month and any succeeding month or months for reports or data not delivered in a complete and correct form.

(2) Subject to the provisions of the TERM and ADMINISTRATION Paragraphs of this Agreement, and the Exhibits(s) attached hereto, County may withhold any claim for payment by Contractor if Contractor has been given at least thirty (30) calendar days' notice of deficiency(ies) in compliance with the terms of this Agreement and has failed to correct such

deficiency(ies). This withholding may be invoked for any month or months for deficiency(ies) not corrected.

(3) Upon acceptance by County of all report(s) and data previously not accepted under this provision and/or upon correction of the deficiency(ies) noted above, County shall reimburse all withheld payments on the next regular monthly claim for payment by Contractor.

(4) Subject to the provisions of the Exhibit(s) of this Agreement, if the services are not completed by Contractor within the specified time, County may withhold all payments to Contractor under this Agreement between County and Contractor until proof of such service(s) is/are delivered to County.

(5) In addition to Subparagraphs (1) through (4) immediately above, Director may withhold claims for payment by Contractor which are delinquent amounts due to County as determined by a cost report settlement, audit report settlement, or financial evaluation report, resulting from this or prior years' Agreement(s).

J. Contractor agrees to reimburse County for any federal, State, or County audit exceptions resulting from noncompliance herein on the part of Contractor or any subcontractor.

K. Fiscal Viability: Contractor must be able to carry the costs of its program without reimbursement from the contract for at least sixty (60) days at any point during the term of the contract in this Agreement.

L. Contractor Expenditure Reduction Flexibility: In order for County to maintain flexibility with regards to budget and expenditures reductions, Contractor agrees that Director may cancel this Agreement, without cause, upon the giving of thirty (30) calendar days written notice to Contractor; or notwithstanding, ALTERATION OF TERMS of this Agreement, Director, may, consistent with federal, State, and/or County budget reductions, renegotiate the scope/description of work, maximum obligation, and budget of this Agreement via an Administrative Amendment, as mutually agreed to and executed by the parties therein.

9. Paragraph ___, GENERAL INSURANCE REQUIREMENTS, shall be amended and replaced in its entirety to read as follows:

"___. GENERAL INSURANCE REQUIREMENTS: Without limiting Contractor's indemnification of County and in the performance of this Agreement and until all of its obligations pursuant to this Agreement have been met, Contractor shall provide and maintain at its own expense insurance coverage satisfying the requirements specified in Paragraphs _____ of this Agreement. These minimum insurance coverage terms, types and limits (the "Required Insurance") also are in addition to and separate from any other contractual obligation imposed upon Contractor pursuant to this Agreement. The County in

no way warrants that the Required Insurance is sufficient to protect the Contractor for liabilities which may arise from or relate to this Agreement. Such insurance shall be primary to and not contributing with any other insurance or self-insurance programs maintained by County, and such coverage shall be provided and maintained at Contractor's own expense.

A. Evidence of Insurance: Certificate(s) of insurance coverage (Certificate) satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under the Contractor's General Liability policy, shall be delivered to County at the address shown below and provided prior to commencing services under this Agreement.

B. Renewal Certificates: Renewal Certificates shall be provided to County not less than 10 days prior to Contractor's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Contractor and/or subcontractor insurance policies at any time.

(1) Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Agreement by name or number, and be signed by an authorized representative of the insurer(s).

(a) The Insured party names on the Certificate shall match the name of the Contractor identified as the contracting party in this Agreement.

(b) Certificates shall provide the full name of each insurer providing coverage, its National Association of Insurance Commissioners (NAIC) identification number, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding Fifty Thousand Dollars ($50,000), and list any County required endorsement forms.

(c) Neither the County's failure to obtain, nor County's receipt of, or failure to object to a non-complying insurance certificate or endorsement, or any other insurance documentation or information provided by the Contractor, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

(2) Certificates and copies of any required endorsements shall be s delivered to County's of Los Angeles, Department of Public Health, Office of AIDS Programs and Policy, Contract Administration Division, 600 South Commonwealth Avenue, 10th Floor, ATTN: Contract Administration, Los Angeles, California, 90005, prior to commencing services under this Agreement.

(3) Contractor also shall promptly report to County any injury or property damage accident or incident, including any injury to a Contractor employee occurring on county property, and any loss, disappearance, destruction, misuse, or theft of County

property, monies or securities entrusted to Contractor. Contractor also shall promptly notify County of any third party claim or suit files against Contractor or any of its subcontractors which arises from or relates to this Agreement, and could result in the filing of a claim or lawsuit against Contractor and/or County.

C. Additional Insured Status and Scope of Coverage: The County of Los Angeles, its Special Districts, Elected Officials, Officers, Agents, Employees and Volunteers (collectively County and its Agents) shall be provided additional insured status under Contractor's General Liability policy with respect to liability arising out of Contractor's ongoing and completed operations performed on behalf of the County. County and its Agents additional insured status shall apply with respect to liability and defense of suits arising out of the Contractor's acts or omissions, whether such liability is attributable to the Contractor or to the County. The full policy limits and scope of protection also shall apply to the County and its Agents as an additional insured, even if they exceed the County's minimum Required Insurance specifications herein. Use of an automatic additional insured endorsement form is acceptable providing it satisfies the Required Insurance provisions herein.

D. Cancellation of Insurance: Except in the case of cancellation for non-payment of premium, Contractor's insurance policies shall provide, and Certificates shall specify, that County shall receive not less than thirty

(30) days advance written notice by mail of any cancellation of the Required Insurance. Ten (10) days prior notice may be given to County in event of cancellation for non-payment of premium.

E. Failure to Maintain Insurance Coverage: Contractor's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of this Agreement, upon which County immediately may withhold payments due to Contractor, and/or suspend or terminate this Agreement. County, at its sole discretion, may obtain damages from Contractor resulting from said breach. Alternatively, County may purchase such required insurance coverage, and without further notice to Contractor, County may deduct from sums due to Contractor any premium costs advanced by County for such insurance.

F. Insurer Financial Ratings: Insurance coverage shall be placed with insurers acceptable to the County with an A.M. Best rating of not less than A: VII unless otherwise approved by County.

G. Contractor's Insurance Shall Be Primary: Contractor's insurance policies, with respect to any claims relates to this Agreement, shall be primary with respect to all other sources of coverage available to Contractor. Any County maintained insurance or self-insurance coverage shall be in excess of and not contribute to any Contractor coverage.

H. Waivers of Subrogation: To the fullest extent permitted by law, the Contractor hereby waives its rights and its insurer(s)' rights of recovery against County under all the Required Insurance for any loss arising from or relating to this Agreement. The Contractor shall require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

I. Insurance Coverage Requirements for Subcontractors: Contractor shall include all subcontractors as insured under Contractor's own policies, or shall provide County with each subcontractor's separate evidence of insurance coverage. Contractor shall be responsible for verifying each subcontractor complies with the Required Insurance provisions herein, and shall require that each subcontractor name the County and Contractor as additional insured on the subcontractor's General Liability policy. Contractor shall obtain County's prior review and approval of any subcontractor request for modification of the Required Insurance.

J. Deductibles and Self-Insured Retentions (SIRs): Contractor's policies shall not obligate the County to pay any portion of any Contractor deductible or SIR. The County retains the right to require Contractor to reduce or eliminate policy deductibles and SIRs as respects the County, or to provide a bond guaranteeing Contractor's payment of all deductibles and SIRs, including all related claims investigation, administration and

defense expenses. Such bond shall be executed by a corporate surety licensed to transact business in the State of California.

K. Claims Made Coverage: If any part of the Required Insurance is written on a claim made basis, any policy retroactive date shall precede the effective date of this Agreement. Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following Contract expiration, termination or cancellation.

L. Application of Excess Liability Coverage: Contractors may use a combination of primary, and excess insurance policies which provide coverage as broad as ("follow form" over) the underlying primary policies, to satisfy the Required Insurance provisions.

M. Separation of Insureds: All liability policies shall provide cross-liability coverage as would be afforded by the standard ISO (Insurance Services Office, Inc.) separation of insureds provision with no insured versus insured exclusions or limitations.

N. Alternative Risk Financing Programs: The County reserves the right to review, and then approve, Contractor use of self-insurance, risk retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents shall be designated as an Additional Covered Party under any approved program.

O. County Review and Approval of Insurance Requirements: The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon County's determination of changes in risk exposures.. The County and its Agents shall be designated as an Additional Covered Party under any approved program."

10. Paragraph ____, INSURANCE COVERAGE REQUIREMENTS, shall be amended and replaced in its entirety to read as follows:

" ___. INSURANCE COVERAGE REQUIREMENTS:

A. General Liability Insurance (providing scope of coverage equivalent to ISO policy form CG 00 01), naming County and its Agents as an additional insured, with limits of not less than the following:

| | |
|---|---|
| General Aggregate: | $2 Million |
| Products/Completed Operations Aggregate: | $1 Million |
| Personal and Advertising Injury: | $1 Million |
| Each Occurrence: | $1 Million |

Such coverage also shall cover liability arising from any actual or alleged infringement of any patent or copyright, or other property rights of any third party. The policy also shall be endorsed to provider media liability coverage for claims arising out of Contractor's placement of print and audiovisual media. Alternatively, Contractor may provide such media liability coverage under a separate policy or through Contractor's errors and omissions policy.

B. Automobile Liability Insurance (providing scope of coverage equivalent to ISO policy form CA 00 01) with limits of not less than $1 Million for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance shall cover liability arising out of Contractor's use of autos pursuant to this Agreement, including "owned", "leased", "hired" and/or "non-owned" vehicles, or coverage for "any auto", as each may be applicable.

C. Workers Compensation and Employers' Liability: Insurance providing workers compensation benefits, as required by the Labor Code of the State of California or by any other state, and for which Contractor is responsible. Insurance or qualified self-insurance satisfying statutory requirements, which includes Employers' Liability coverage with limits of not less than $1 Million per accident. If Contractor will provide leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that County will receive not less than thirty (30) days advance written notice of cancellation of this coverage provision. If applicable to Contractor's operations, coverage also shall be arranged to satisfy the requirements of

any federal workers or workmen's compensation law or any federal occupational disease law.

In all cases, the above insurance also shall include Employers' Liability coverage with limits of not less than the following

| | |
|---|---|
| Each Accident: | $1 Million |
| Disease – Policy Limit: | $1 Million |
| Disease – Each Employee | $1 Million |

D. Professional Liability Insurance: Insurance covering Contractor's liability arising from or related to this Agreement, any error, omission, negligent or wrongful act of Contractor, its officers or employees with limits of not less than $3 Million per occurrence and/or claim and $6 Million aggregate. The coverage also shall provide an extended two-year reporting period commencing upon expiration or earlier termination or cancellation of this Agreement. Further, Contractor understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Agreement's expiration, termination or cancellation.

E. Sexual Misconduct Liability: Insurance covering actual or alleged claims for sexual misconduct and/or molestation with limits of not less than $2 million per claim and $2 million aggregate, and claims for negligent employment, investigation, supervision, training or retention of, or failure to report to proper authorities, a

person(s) who committed any act of abuse, molestation, harassment, mistreatment or maltreatment of a sexual nature."

11. Exhibit(s) ___, SCOPES OF WORK FOR HIV/AIDS {ENTER SERVICE CATEGORY} SERVICES, is/are attached hereto and incorporated herein by reference.

12. Schedule ___, BUDGET FOR HIV/AIDS {ENTER SERVICE CATEGORY} SERVICES, is attached hereto and incorporated herein by reference.

13. Except for the changes set forth hereinabove, Agreement shall not be changed in any respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its Director of Public Health, and and Contractor has caused this Amendment to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Jonathan E. Fielding, M.D., MPH
Director and Health Officer

_____
Contractor

By _____
Signature

_____
Printed Name

Title _____
(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM
BY THE OFFICE OF THE COUNTY COUNSEL
ROBERT E. KALUIAN
Acting County Counsel

APPROVED AS TO CONTRACT
ADMINISTRATION:

Department of Public Health

By _____
Gary T. Izumi, Chief
Contracts and Grants

**EXHIBIT «Exhibit_Letter»**

**«Agencys_NameCAPS»**

**HUMAN IMMUNODEFICIENCY VIRUS (HIV)/
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)
{ENTER SERVICE CATEGORY} SERVICES**

1. DESCRIPTION: Mental health treatment for people living with HIV attempts to enhance access to and retention in primary HIV medical care and promote health and quality of life. Counseling and psychotherapy have been shown to be helpful in alleviating or decreasing psychological symptoms that can accompany a diagnosis of HIV. Often, people living with HIV bring issues that pre-date their infection, but have been exacerbated by the stress of living with a chronic illness.

HIV/AIDS mental health, psychotherapy services are short-term or sustained therapeutic interventions provided by mental health professionals for clients experiencing acute and/or ongoing psychological distress.

Mental health, psychotherapy services include client intake; biopsychosocial assessment and reassessment; development of treatment plans; psychotherapeutic treatment (i.e., individual, family/conjoint, and/or group psychotherapy); drop-in psychoeducational groups; and crisis intervention. Psychotherapeutic treatment includes ongoing contact and clinical interventions with or on behalf of a client to meet pre-determined collaboratively developed treatment goals. Interventions are performed through various modalities: (1) individual - the treatment unit is the individual seeking

psychotherapy services, (2) family/conjoint - the treatment unit is the family or couple (as defined by the client), and (3) group psychotherapy - the treatment unit is a group of clients. Mental health, psychotherapy services are usually provided on a regularly scheduled basis with arrangements made for non-scheduled visits during times of increased stress or crisis.

All mental health psychotherapeutic interventions shall be based on proven clinical methods and in accordance with legal and ethical standards. Maintaining confidentiality is of critical importance. All programs shall comply with the Health Insurance Portability and Accountability Act (HIPAA) standards for information disclosure.

2. PERSONS TO BE SERVED: HIV/AIDS mental health, psychotherapy services shall be provided to indigent persons with HIV/AIDS residing within Los Angeles County in accordance with Attachment 1, "Service Delivery Site Questionnaire", attached hereto and incorporated herein by reference.

3. COUNTY'S MAXIMUM OBLIGATION: During the period of March 1, 2010 through February 28, 2011, that portion of County's maximum obligation which is allocated under this Exhibit for HIV/AIDS mental health, psychotherapy services shall not exceed «Max_ObligationSpell_Out» Dollars ($«Max_Obligation»).

During the period of March 1, 2011 through February 28, 2012, that portion of County's maximum obligation which is allocated under this Exhibit for HIV/AIDS mental health, psychotherapy services shall not exceed «Max_ObligationSpell_Out» Dollars ($«Max_Obligation»).

The contract term shall be one (1) twelve (12) month period. The renewal options will be at the sole discretion of the Director of Public Health or his designee. Continued funding beyond this term will be dependent upon Contractor performance and the availability of funding.

4. COMPENSATION: County agrees to compensate Contractor for performing services hereunder for actual reimbursable net cost as set forth in Schedules «Schedules_number». Payment for services provided hereunder shall be subject to the provisions set forth in the BILLING AND PAYMENT Paragraph of this Agreement. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets.

5. CLIENT ELIGIBILITY: Contractor shall be responsible for developing and implementing client eligibility criteria. Such criteria shall include client's HIV status, residency in Los Angeles County, and income. Verification of client's Los Angeles County residency and income shall be conducted on an annual basis. In addition, eligibility criteria shall address the following:

A. Contractor shall prioritize delivery of services to clients who live at or below one hundred percent (100%) of the Federal Poverty Level and who have the greatest need for mental health, psychotherapy services.

B. Clients who live above one hundred percent (100%) of the Federal Poverty Level may also be eligible for services. This is dependent upon the threshold for eligibility as determined by the annual priority and allocation decisions.

C. Client's annual healthcare expenses that are paid for through use of the client's income shall be considered deductions against the client's income for the purposes of determining the client's income level.

6. CLIENT FEE SYSTEM: Contractor shall comply with provisions of Section 2605 (e) of Title 26 (CARE Act) which is entitled "Requirements Regarding Imposition of Charges for Services", incorporated into this Agreement as Exhibit.

Contractor shall be responsible for developing and implementing a client fee system. Such system shall include, but not be limited to, the following components: (1) procedures and forms used in financial screening of clients; (2) schedule of fees; (3) procedures and forms used in determining whether client is covered by any third party payor, such as Medicare, Medi-Cal, managed care program, or other private insurance; (4) description of mechanism or procedures used in assisting clients in applying for public benefits, entitlement programs, and/or other health insurance programs for which they may be eligible; and (5) the frequency intervals of subsequent client financial screenings.

7. SERVICE DELIVERY SITES: Contractor's facilities where services are to be provided hereunder are located at: «Enter Service Delivery Site Address».

Contractor shall request approval from Office of AIDS Programs and Policy (OAPP) in writing a minimum of thirty (30) days before terminating services at such locations and/or before commencing services at any other locations.

A memorandum of understanding shall be required for service delivery sites on locations or properties not owned or leased by Contractor with the service provider who

owns or leases such location or property. This shall include coordination with another agency, community based organization, and/or County entity. Contractor shall submit memoranda of understanding to OAPP for approval at least thirty (30) days prior to implementation.

8. SERVICES TO BE PROVIDED: During each period of this Agreement, Contractor shall provide HIV/AIDS mental health, psychotherapy services to eligible clients in order to enhance access to and retention in primary HIV medical care and promote health and quality of life, in accordance with procedures formulated and adopted by Contractor's staff, consistent with laws, regulations, the Los Angeles County Commission on HIV Standards of Care for Mental health, psychotherapy Services, professional mental health standards, and the terms of this Agreement.

A. Contractor shall provide a minimum of «minimum goals spell out» («minimum goals in numbers») hours of individual psychotherapy services to a minimum of «minimum goalspell out» («minimum goals in numbers») unduplicated clients.

B. Contractor shall provide a minimum of «minimum goals spell out» («minimum goals in numbers») hours of family/conjoint psychotherapy services to a minimum of «minimum goals spell out» («minimum goals in numbers») unduplicated clients.

C. Contractor shall provide a minimum of «minimum goals spell out» («minimum goals in numbers») hours of group psychotherapy services to a

minimum of «minimum goals spell out» («minimum goals in numbers») unduplicated clients.

D. Units of Service, defined as reimbursement for HIV/AIDS mental health, psychotherapy services, shall be based on time spent providing, documenting, and receiving consultation/supervision for direct mental health treatment services.

(1) Individual Psychotherapy Units are calculated in number of hours provided for psychotherapeutic treatment sessions performed in an individual modality.

(2) Family/Conjoint Psychotherapy Units are calculated in number of hours provided for psychotherapeutic treatment sessions performed in a family/conjoint modality.

(3) Group Psychotherapy Units are calculated in number of hours provided for psychotherapeutic treatment sessions performed in a group modality.

(4) Drop-In Group Psychoeducational Units are calculated in number of hours provided for psychoeducational group sessions conducted.

(5) Crisis Intervention Units are calculated in number of hours provided for counseling sessions related to crisis intervention services.

E. Number of clients who receive individual, family/conjoint, and/or group psychotherapy, and crisis intervention services shall be documented using the figures for unduplicated clients within a given contract period.

F. Promoting availability of HIV/AIDS mental health, psychotherapy services for persons with HIV disease through outreach and contact with HIV/AIDS service organizations and other service providers. Contractor shall develop an Outreach Plan that demonstrates collaboration with County funded HIV/AIDS medical outpatient provider(s) within Service Planning Area (SPA) «Enter SPAs» and to promote their activities to clients and HIV service organizations. The Outreach Plan shall include, but not be limited to: 1) a written strategy for the provision of mental health, psychotherapy services that links with medical outpatient services; 2) assessment of other available resources and services; 3) timeline for implementation; 4) memoranda of understanding with community based organizations to formalize linkages; and 5) evaluation plan. Contractor shall submit outreach plan to OAPP within forty-five (45) days of the full execution of this Agreement. Contractor shall obtain written approval from OAPP prior to implementing the Plan.

G. Contractor shall ensure agency participation in a provider network or task force for HIV/AIDS mental health services. Contractor shall coordinate mental health, psychotherapy services with other HIV/AIDS mental health services provided within SPAs «Enter SPAs».

H. Contractor shall ensure that all clients receiving mental health, psychotherapy services are linked to HIV/AIDS primary health care services. Documentation of primary health care provider information and referrals shall be updated on an ongoing basis.

9. DIRECT SERVICES: During each period of this Agreement, Contractor shall provide HIV/AIDS mental health, psychotherapy services as required by OAPP, including but not be limited to, the following activities:

A. Client Intake: All clients who request or are referred to HIV services are required to complete the client intake process. Client intake determines if a person is eligible for mental health, psychotherapy services and includes client demographic data, emergency contact and next of kin information, and eligibility documentation. The intake process also acquaints the person with the range of services offered and determines the potential client's interest in such services. Client intake shall be completed in the first contact with the potential client. Contractor shall maintain a client record for each eligible client receiving mental health, psychotherapy services. All required documentation shall be maintained within each client record, including required intake information, forms, and eligibility documentation.

(1) Required Intake Information: Contractor shall obtain and document client intake information that includes, but not be limited to: date of intake; client name, home/residential address, mailing address, and telephone number; emergency contact name, home address, and

telephone number; next of kin name, home address, and telephone number; and client demographic data as required by OAPP;

(2) Required Intake Forms: Contractor shall develop the following forms in accordance with state and local guidelines. Completed forms, signed and dated by the client, are required for each client, including:

(a) Release of Information (must be updated annually). New forms must be added for those individuals not listed on the existing Release of Information. Release of Information shall detail the specific person(s) or agency(ies) to whom information will be released and the specific type of information to be released;

(b) Confidentiality policy, including Limits of Confidentiality;

(c) Consent to Receive Services;

(d) Client Rights and Responsibilities;

(e) Client Grievance Procedures.

(3) Required Eligibility Documentation: Contractor shall obtain the following client eligibility documentation:

(a) Proof of HIV diagnosis;

(b) Proof of income (must be verified on an annual basis);

(c) Proof of residence in Los Angeles County (must be verified on an annual basis).

B. Biopsychosocial Assessment: The biopsychosocial assessment is completed during a collaborative face-to-face interview in which the client's

biopsychosocial history and current presentation are evaluated by a professional mental health provider to determine diagnosis, treatment needs, and ability to access and retain primary HIV medical care and promote health and quality of life. A comprehensive biopsychosocial assessment is required for all clients receiving individual, family/conjoint, and/or group psychotherapy. These assessments are not required for clients receiving crisis intervention services and participants of drop-in psychoeducational groups.

The comprehensive biopsychosocial assessment shall be completed within two (2) sessions, but not more than thirty (30) days from client's date of intake. If the assessment cannot be completed within thirty (30) days, the reason for the delay and all attempts made to complete the assessment shall be documented within the progress notes. Assessments shall support the psychotherapeutic treatment modality chosen.

Reassessments shall be conducted on an ongoing basis as driven by client need, when there is a significant change in the client's status or when the client has left and re-entered psychotherapy treatment services and shall address whether this service has contributed to the client's ability to access and retain primary HIV medical care, but at minimum of once every twelve (12) months. Reassessments shall be fully documented utilizing a new assessment form or within the progress notes. Assessments and reassessments shall be maintained within the client record.

Biopsychosocial assessments shall, at a minimum, consist of the following required documentation:

(1) Progress note and assessment form referencing the actual date(s) the assessment or reassessment was conducted, time spent, and, if the assessment was not completed, plans to complete the assessment as necessary;

(2) Statement of the client's presenting problem/chief complaint;

(3) Psychiatric and mental health psychotherapy treatment history, including: hospitalizations, outpatient treatment, and history of onset of current symptoms/precipitating events;

(a) Impact of periods of treatment and non-treatment on functioning;

(4) Substance use history, including current and past use of alcohol and/or drugs and substance use treatment;

(5) Psychosocial history, including: history and current description of family, relationships, and support systems (including physical, sexual, and domestic violence history); family history of mental illness and substance use; dependent care issues; and living conditions and environment;

(6) Cultural influences, including: spiritual and/or religious belief systems, church affiliation, sexual orientation and gender roles, and discrimination;

(7) Education and employment history, including: highest grade completed, literacy level, general knowledge and skills, means of financial support (including source of income), and work related problems;

(8) Legal history, including: type and frequency of arrests and/or convictions, parole and/or probation status, and divorce and child custody issues;

(9) General medical history and health, including: diet/nutrition, sleep, and exercise;

(10) HIV-related medical history, including: month and year of HIV diagnosis, date and results of last T-cell count and viral load, and history and current presence of any HIV-related illnesses or symptoms;

(11) Medication and treatment adherence issues, including: history, barriers, side effects, and coping skills;

(12) HIV risk behaviors and risk/harm reduction, including: history of sexual risk taking behaviors, barriers to change, and risk/harm reduction plan;

(13) Mental status exam that includes, at a minimum, the following: appearance; motor activity; attitude; mood and affect; speech and language fluency (including rate and quality); thought content, process, and perception (including connectedness, predominant topic, delusions, preoccupations/obsessions, hallucinations); orientation (including time, place, person, and purpose); memory (short-term and long-term);

judgment and insight; and suicidal and violent ideation and history (including type and frequency of ideation, past attempts, and plan);

(14) Complete *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Text Revision* (DSM IV-TR) five-axis diagnosis, including a description of symptoms and diagnostic criteria that justify the diagnosis. In all cases where the initial diagnosis on one (1) or more Axis is deferred, the mental health provider shall continue to assess the client concurrent with treatment and complete the diagnosis within sixty (60) days of Psychosocial Assessment. This or any other change in diagnosis should be clearly documented in a progress note or on a Change of Diagnosis form.

Biopsychosocial assessments and reassessments shall include the date, signature, and title of the mental health provider conducting the assessment interview. Biopsychosocial assessments and reassessments completed by unlicensed mental health providers shall be co-signed by the licensed clinical supervisor.

C. Treatment Plan: Treatment plans are developed in collaboration with the client and determine the course of mental health, psychotherapy treatment. Biopsychosocial assessments and treatment plans should be developed concurrently; however, treatment plans shall be finalized within two (2) weeks of the completion of the biopsychosocial assessment. Treatment plan goals should address mental health issues that prevent access to and retention in primary HIV

medical care. Treatment plans shall be developed by the same mental health provider that conducts the biopsychosocial assessment. Treatment plans are required for all clients receiving individual, family/conjoint, and/or group psychotherapy. Treatment plans are not required for clients receiving crisis intervention services and participants of drop-in psychoeducational groups.

The treatment plan shall be reviewed and updated on an ongoing basis, but at a minimum of every six (6) months. Such updates shall be documented within the client record. Contractor shall ensure that the mental health, psychotherapy providers continue to address and document existing and newly identified treatment plan goals. A copy of the treatment plan shall be provided to the client.

Psychotherapy treatment plans shall be maintained within the client record and include, at a minimum, the following required documentation:

(1) Statement of the problems, symptoms, or behaviors to be addressed in treatment;

(2) Goals (desired outcomes) and objectives (measurable change in symptoms or behaviors);

(3) Interventions proposed

(4) Appropriate modalities (individual, family/conjoint, and/or group psychotherapy) to address the identified problem(s);

(5) Frequency and expected duration of services;

(6) Service referrals (e.g., psychiatric consult, substance abuse treatment, etc.).

Treatment plans shall be signed and dated by the mental health provider and the client. Treatment plans completed by unlicensed mental health providers shall be co-signed by the licensed clinical supervisor.

D. Treatment Provision: Mental health, psychotherapy treatment provision consists of ongoing contact and clinical interventions with or on behalf of the client to meet pre-determined collaboratively developed treatment goals. Interventions can be performed in a variety of modalities: (1) individual counseling/psychotherapy - treatment unit is the individual seeking mental health services, (2) family or conjoint counseling/psychotherapy - treatment unit is the family or couple (as defined by the client), and/or (3) group counseling/psychotherapy - treatment unit is a group of clients. Ongoing contact and clinical interventions shall include, but not be limited to: ongoing individual, family/conjoint, and group psychotherapeutic sessions; referrals to psychiatrists as needed for psychiatric consultations, evaluations, prescription of psychotropic medications and follow-up of such medications; consultation with other service providers; resource coordination; and follow-up. Ongoing contact includes evaluation of the client's status to determine whether change in the client's care and treatment is warranted. All treatment provision activities shall be documented within the client progress notes and maintained within the client record.

(1) All modalities and interventions in mental health, psychotherapy treatment shall be guided by the needs expressed in the treatment plan. Practitioners shall be knowledgeable about outcome research and shall utilize clinically proven treatment for their client's presenting problems. Treatment shall enhance client's ability to access and retain primary HIV medical care and promote health and quality of life. Treatment shall conform to the standards of care recognized within the general community and supported by clinically published research for the client's condition.

(2) The provision of specific types of psychotherapy (e.g., behavioral, cognitive, post-modern, and psychodynamic) is guided by the individual client's need and based on published practice guidelines and research. For those clients on psychotropic medications, side effects of these agents should be assessed at each visit, along with the provision of education regarding such medications, within the scope of the mental health provider's practice. As indicated, these clients shall be referred back to the prescribing physician for further information.

(3) Mental health, psychotherapy treatment shall include exploration of and counseling regarding:

(a) Knowledge of modes of HIV transmission, HIV prevention, and risk and harm reduction strategies (including root causes and underlying issues related to increased HIV transmission behaviors);

(b) Ability to enhance access to and retention in primary HIV medical care and promote health and quality of life;

(c) Substance use;

(d) Medical and psychotropic treatment adherence;

(e) Development of social support systems and community resources as indicated by the client's circumstances;

(f) Maximizing social and adaptive functioning.

(4) Additional considerations for ongoing psychotherapy sessions include:

(a) The role of culture, spirituality, and religion in the client's life should be understood and utilized as strength when present;

(b) For clients experiencing physical deterioration, practitioner should assist clients with issues related to disability, death, and dying;

(c) For clients whose health has improved, practitioner should explore future goals, including returning to work or school;

(d) When a signed release has been completed, sources of support and care can be recommended to significant others and family members.

(5) Specific treatment modalities and clinical interventions are described as follows:

(a) Individual Counseling/Psychotherapy: Individual counseling or psychotherapy may be either short- or long-term in duration, depending on the needs outlined in the treatment plan. Short-term or brief therapy usually lasts up to twenty (20) sessions and can be most useful when client goals are specific and circumscribed. Longer term therapy provides a means to explore more complex issues that may interfere with a client's quality of life. Even in the case of longer term therapy, specific, short-term, mutually defined goals shall be required to focus treatment and measure progress;

(b) Family Counseling/Psychotherapy: A family may be defined as either the family of origin or a chosen family. The overall goal of family counseling or psychotherapy is to help families improve their functioning, given the complications of living with HIV. Interventions with the family system can be especially effective in helping children and caregivers with behavioral problems and symptoms;

(c) Conjoint or Couples Counseling/ Psychotherapy: Conjoint or couples counseling/ psychotherapy is most appropriate where the presenting problem is dissatisfaction or conflict within a relationship that impacts the person living with HIV. In cases of domestic violence, couples counseling should not begin until the

provider determines the appropriateness of this modality based upon the progress both parties have made in individual or group treatment and that current violence is no longer a risk. If these criteria are not met, members of such couples shall be referred for individual or group treatment;

(d) Group Psychotherapy Treatment: Group psychotherapy treatment can provide opportunities for increased psychosocial support vital to those isolated by HIV. Groups may be led by a single professional mental health provider; however, there are significant benefits when utilizing two (2) professional mental health providers as co-facilitators. Such benefits include: fewer group cancellations due to facilitator absence, increased chance that important individual and group issues will be explored, members have the opportunity to witness different skills and styles of the therapists, and increased opportunity to work through transference relationships.

Group psychotherapy treatment can be provided in a variety of formats. Psychotherapy groups, either open or closed, shall be part of an individual client's treatment plan with the client's progress documented within the client record.

i) Closed psychotherapy treatment groups require a process for joining and terminating from the group and

usually have a set number of group members (between six and ten). This format provides an opportunity to build group cohesion and for members to take part in active interpersonal learning. Closed psychotherapy treatment groups can be time limited or ongoing, issue specific or more general in content.

ii) Open psychotherapy treatment groups do not require ongoing participation from clients. The group membership may shift from session to session. This format often requires group facilitators to be more structured and active in their psychotherapeutic approach. Open psychotherapy treatment groups can be especially useful to clients requiring immediate support, but unsure about making a commitment to ongoing mental health treatment.

(6) Treatment provision activities shall be documented through progress notes and maintained within the individual client record and group process notes. Progress notes for individual, family/conjoint, and group psychotherapy shall include, at a minimum, the following information:

(a) Date, type of contact, and the time spent with or on behalf of the client;

(b) Notation related to conducting an assessment or reassessment;

(c) Notation related to the development of or update to treatment plan;

(d) Progress towards treatment plan goals;

(e) Interventions provided and the client's response to interventions;

(f) Referrals provided (e.g., psychiatric consult, case management, medical services, substance abuse treatment, etc.);

(g) Results of interventions and referrals;

(h) Documentation that the provider has addressed existing and newly identified treatment plan goals and issues;

(i) Use of outcome research and published standards of care that guide treatment;

(j) Counseling provided regarding HIV related issues, stabilizing mental health, and maximizing social and adaptive functioning (e.g., HIV prevention, harm/risk reduction, substance use, treatment adherence, etc.);

(k) Assessments for and education about medication side effects and counseling regarding psychotropic medication adherence;

(l) Contacts and attempted contacts made with primary health care providers and other service providers for the coordination and integration of care;

(m) Client follow-up activities, including contacts, attempted contacts, and written correspondence provided;

(n) Documentation regarding exceptions or special circumstances related to client care and treatment;

(o) Documentation for psychotherapy treatment groups shall also include for each group conducted:

i) Date, time, and length of the group;

ii) Name, title, and signature of group facilitator(s);

iii) Record of attendance;

iv) Issues discussed and interventions provided relative to the group process and each individual client.

Progress notes, including documentation of psychotherapy treatment groups, shall include the date, signature, and title of the mental health provider(s) conducting the mental health, psychotherapy services. Such progress notes completed by unlicensed mental health providers shall be co-signed by the licensed clinical supervisor.

E. Drop-In Psychoeducational Groups: Drop-in psychoeducational groups do not have an ongoing membership. These groups do not focus on

psychotherapeutic treatment interventions for clients. Instead, these drop-in psychoeducational groups focus on such functions as providing topic-specific education, social support, and emotional encouragement. To be offered as a mental health service, all drop-in psychoeducational groups must be facilitated by at least one (1) professional mental health provider as defined in the STAFFING REQUIREMENTS AND QUALIFICATIONS Paragraph of this Agreement. For this service, the mental health provider may be assisted by a paraprofessional worker (a lay person with specialized training working under the supervision of a mental health professional). The paraprofessional shall not be permitted to operate independently.

Participation in drop-in psychoeducational groups does not require inclusion in a client's treatment plan and a full biopsychosocial assessment is not required to access this service. In addition, documentation for drop-in psychoeducational groups does not require individual client progress notes. Required documentation for these drop-in groups shall be completed by the mental health professional and shall include, at a minimum, for each group conducted:

(1) Date, time, and length of the group;

(2) Name, title, and signature of group facilitator(s);

(3) Record of participant attendance;

(4) Issues discussed and interventions provided.

Documentation of drop-in psychoeducational groups shall include the date, signature, and title of the mental health provider conducting this service. If the mental health provider is unlicensed, drop-in psychoeducational group documentation shall be co-signed by the licensed clinical supervisor.

F. Crisis Intervention: Crisis intervention services are unplanned services provided to an individual, couple, or family experiencing biopsychosocial distress. These services are provided in order to prevent crisis-related deterioration of client functioning and/or to assist in the client's return to baseline functioning. Client safety shall be continuously assessed and addressed when providing these services. Crisis intervention services may be provided face-to-face or by telephone, and as often as necessary, to ensure client safety and maintenance of baseline functioning.

Crisis intervention services shall be documented through progress notes and maintained within the client record. Crisis intervention progress notes shall include, but not be limited to:

(1) Date, time of day, and time spent with or on behalf of the client;

(2) Summary of the crisis event and reasons for crisis intervention services;

(3) Description and details of continuous client safety assessments;

(4) Interventions and referrals provided;

(5) Results of interventions and referrals;

(6) Follow-up plan.

Crisis intervention services documentation shall include the date, signature, and title of the mental health provider. If the mental health provider is unlicensed, crisis intervention services documentation shall be co-signed by the licensed clinical supervisor.

G. Triage/Referral/Coordination: For clients requiring mental health interventions that the mental health provider is not able to provide, the mental health provider shall ensure that these clients are referred to a full-range of mental health services, including psychiatric evaluation and medication management, neuropsychological testing, day treatment programs, and in-patient hospitalization. Mental health, psychotherapy providers shall refer clients to other services as needed, including case management, treatment education, peer support, primary health care, and oral health services. In addition, mental health providers shall refer clients with co-occurring substance abuse disorders to appropriate substance abuse treatment services. To ensure integration of services and optimum client care, mental health services shall be coordinated with all of the services listed previously within this paragraph.

Mental health providers shall contact, or attempt to contact, the client's primary health care provider to coordinate and integrate client care at a minimum of once per every twelve (12) months, or as clinically indicated. Mental health providers shall contact, or attempt to contact, other providers as clinically

indicated. Triage, referral, and coordination activities shall be documented through progress notes and maintained within the client record.

H. Client Retention: Programs shall make every effort to avoid client's falling out of care related to inadequate follow-up while in mental health, psychotherapy services. Contractor shall develop and implement a broken appointment policy and procedure to ensure continuity of services and retention of clients. Follow-up activities may include telephone calls, written correspondence, and/or direct contact, and strives to maintain the client's participation in care. Programs shall provide regular follow-up activities and adhere to broken appointment procedures to encourage and assist clients with maintaining in mental health, psychotherapy services. Program shall determine on a case-by-case basis whether more frequent contact with a particular client is needed in order to avoid potential dropout. These activities and interventions shall be documented through progress notes and maintained within the client record.

I. Case Closure: Case closure refers to the systematic process for discharging clients from mental health, psychotherapy services. This process includes formal notification regarding pending case closure, and the completion of a case closure summary to be maintained within the client record. Clients shall be considered active providing they receive mental health, psychotherapy services at least once within each sixty (60) day period. Case closure activities

shall be initiated if the client does not receive mental health - psychotherapeutic treatment services or is unable to be contacted within a sixty (60) day period.

Case closure may occur for the following reasons: client relocation outside of Los Angeles County, successful attainment of mental health treatment goals, continued non-adherence to treatment plan, inability to contact client, client-driven termination of services, unacceptable client behavior, or client death. For clients who have dropped out of treatment without notice, Contractor shall provide regular follow-up, including attempts to contact the client and written correspondence. Follow-up and case closure activities shall be documented through progress notes and maintained within the client record.

Case closure summaries shall include, at a minimum, the following required documentation:

(1) Date of discharge;

(2) Course of treatment;

(3) Discharge diagnosis;

(4) Referrals provided;

(5) Reason for termination of services;

(6) For clients who have dropped out of treatment without notice, the case closure summary shall include documentation of follow-up activities conducted and attempts to contact the client, including results of these attempted contacts.

(7) Case closure summaries shall include the date, signature, and title of the mental health provider. Case closure summaries completed by unlicensed mental health providers shall be co-signed by the licensed clinical supervisor.

10. PROGRAM RECORDS: Contractor shall maintain client program records as follows:

A. Each client record shall include:

(1) Documentation of HIV/AIDS diagnosis;

(2) Proof of County of Los Angeles residency;

(3) Verification of client's financial eligibility for services;

(4) Client demographic information;

(5) A current and appropriate assessment including date and signature of staff conducting assessment;

(6) A current and appropriate individual service plan including staff's and client's signature or documentation noting the client's acceptance of the plan;

(7) Progress notes documenting referrals provided and interventions made on behalf of the client;

(8) Progress notes documenting results of referrals, interventions, and status of the service plan;

(9) Documentation of case closure activities; and

(10) Documentation of all contacts with and actions taken on behalf of the client including date, time spent, type of contact, what occurred during contact, and signature and title of person providing contact.

B. Documentation of multidisciplinary case conferences shall include, but not be limited to: date of case conference; name, title, and initials of case conference participants, psychosocial issues and concerns identified; description of guidance provided and/or follow-up plan; and results of implementing guidance/follow-up. Documentation of case conferences shall be maintained within each family record.

C. Documentation of clinical supervision of case managers.

D. Documentation of staff/volunteer training.

11. CASE CONFERENCES: Contractor shall conduct multidisciplinary discussions of each active client at a minimum of once every six (6) months. All available members of the treatment team, including case managers, treatment educators, psychiatrists, medical personnel, etc., shall be encouraged to attend. These discussions shall assist mental health providers in problem-solving and monitoring related to a client's progress toward mental health, psychotherapy treatment plan goals.

Documentation of case conferences shall be maintained within each client record and/or in a case conference log. Required documentation for case conferences shall include, but is not limited to:

A. Date of case conference;

B. Names of case conference participants;

C. Name(s) of client(s) discussed;

D. Issues and concerns identified;

E. Mental health psychotherapy follow-up plan;

F. Clinical guidance provided, as appropriate per staff requirements and approved protocol;

G. Verification that the clinical guidance provided has been implemented, as appropriate.

12. ADMINISTRATIVE SUPERVISION: Contractor shall provide administrative oversight of mental health, psychotherapy services.

A. Client Record Reviews: Contractor shall conduct regular reviews of client records to ensure that all required documentation is completed properly in a timely manner and secured within client records. Client record reviews shall include, but not be limited to, the following required documentation: checklist of required documentation signed and dated by the individual conducting the review of mental health client records, written documentation identifying steps to be taken to rectify missing or incomplete documentation, and the date of resolution of required documentation omission. The administrative supervisor shall periodically review the required documentation.

B. Preparation and submission of reports in accordance with the REPORTS Paragraph of this Exhibit.

13. STAFFING REQUIREMENTS AND QUALIFICATIONS: Mental health, psychotherapy providers shall possess the skills, experience, education, and licensing qualifications appropriate for the provision of HIV/AIDS mental health, psychotherapy services.

A. Providers of professional mental health psychotherapy services include licensed practitioners and unlicensed practitioners who practice under the supervision of a licensed mental health professional and as mandated by their respective licensing bodies.

B. Professional mental health providers shall be, at a minimum, Master's or Doctoral level graduate students in social work, counseling, marriage and family therapy, nursing with specialized mental health training, or psychology.

C. If mental health providers are unlicensed, they shall be clinically supervised by a licensed mental health practitioner in accordance with the licensing board of their respective professions. Graduate level students shall be clinically supervised by a licensed mental health practitioner in accordance with the requirements of their academic programs/institutions and to the degree that ensures appropriate practice. Contractor shall immediately notify OAPP, in writing, if an appropriate licensed clinical supervisor is not available.

D. Professional mental health providers are defined as follows:

(1) Licensed Mental Health Practitioners:

(a) Licensed Clinical Social Workers: Licensed Clinical Social Workers (LCSWs) possess a Master's degree in social work

(M.S.W.). LCSWs are required to have accrued three thousand, two hundred (3,200) hours of supervised professional experience in order to qualify for licensing. The Board of Behavioral Science Examiners regulates the provision of mental health services by LCSWs.

(b) Licensed Marriage and Family Therapists: Licensed Marriage and Family Therapists (MFTs) possess a Master's of degree in counseling, clinical psychology, and/or psychotherapy. MFTs are required to have accrued three thousand (3,000) hours of supervised counseling or psychotherapy experience in order to qualify for licensing. The Board of Behavioral Science Examiners regulates the provision of mental health services by MFTs.

(c) Licensed Psychologists: Licensed Psychologists possess a Doctoral degree in psychology or education (Ph.D., Psy.D., and Ed.D.). Psychologists are required to have accrued three thousand (3,000) hours of supervised professional experience in order to qualify for licensing. The Board of Psychology regulates the provision of mental health services by psychologists.

(2) Unlicensed Mental Health Practitioners:

(a) Psychological Assistants, Interns, and Post-Doctoral Fellows; Marriage Family Therapist Interns, and Social Work Associates: These Assistants, Interns, Fellows, and Associates are

accumulating supervised experience as part of their preparation for licensing or certification. They have completed graduate work in psychology, counseling, or social work. These providers require direct supervision by a licensed mental health practitioner as mandated by their respective licensing bodies.

(b) Marriage Family Therapist Trainees, Registered Marriage Family Therapist Interns and Social Work Interns: These Trainees and Interns are in the process of obtaining their Master's degrees and completing the necessary practicum or field work in a site approved by their academic institutions. Trainees and Interns require direct supervision by a licensed mental health practitioner at the approved site as mandated by their academic institutions.

E. Contractor shall maintain documentation of staff qualifications within each personnel record. Documentation shall include the appropriate licensure, degree(s), professional status, student status and educational program, and resumé. Contractor shall ensure that unlicensed mental health providers receive supervision by a licensed mental health practitioner in accordance with state licensing requirements and/or academic programs/institutions. Documentation of supervision shall be maintained within personnel records or within a separate supervision file/log.

F. All mental health practitioners shall possess the ability to provide developmentally and culturally appropriate care to clients living with and affected by HIV.

G. All staff providing clinical supervision shall have previous training and experience utilizing appropriate mental health treatment modalities in practice.

H. All mental health practitioners shall participate in orientation and training prior to beginning treatment provision.

I. Licensed mental health practitioners are encouraged to seek consultation to address clinical, psychosocial, developmental, and programmatic issues, as needed.

J. All mental health practitioners should have training and experience with HIV/AIDS related issues and concerns. Contractor shall provide and/or allow access to ongoing staff development and training regarding HIV-related mental health issues. It is recommended that mental health practitioners participate in continuing education and training on issues related to HIV and mental health on a quarterly basis. Practitioners providing mental health, psychotherapy services to people living with HIV/AIDS shall possess knowledge about the following subjects, at a minimum:

(1) HIV disease process and current medical treatments;

(2) Medication interactions;

(3) Psychosocial issues related to HIV/AIDS;

(4) Cultural issues related to communities affected by HIV/AIDS;

(5) Mental disorders related to HIV and/or other medical conditions;

(6) Mental disorders that can be induced by prescription drug use;

(7) Adherence to medication regimes;

(8) Diagnosis and assessment of HIV-related mental health issues;

(9) HIV/AIDS legal and ethical issues;

(10) Knowledge of human sexuality, gender, and sexual orientation issues;

(11) Substance abuse theory, treatment, and practice.

K. Documentation of staff development and trainings shall be maintained within each personnel record, including but not limited to:

(1) Date, time, and location of the function;

(2) Function type;

(3) Name of the agency and staff members attending the function;

(4) Name of the sponsor or provider;

(5) Training outline, meeting agenda, and/or minutes.

L. Mental health practitioners and staff shall be aware of and be able to practice under the legal and ethical obligations as set forth by California state law and their respective professional organizations. Mental health providers shall comply with existing laws regarding confidentiality, informed consent and client's rights, and shall conform to the standards and guidelines of the American

Psychological Association and the National Association of Social Workers regarding ethical conduct, including:

(1) Duty to Treat: Practitioners have an ethical obligation not to refuse treatment because of fear or lack of knowledge about HIV;

(2) Confidentiality: Maintenance of confidentiality is a primary legal and ethical responsibility of the mental health practitioner. Limits of confidentiality include: danger to self or others, grave disability, child/elder abuse, and, in some cases, domestic violence;

(3) Duty to Warn: Serious threats of violence against a reasonably identifiable victim shall be reported. At present, in California, a person living with HIV/AIDS engaging in behaviors that may put others at risk for HIV infection is not a circumstance that warrants breaking of confidentiality. Only physicians may notify identified partners who may have been infected, other mental health practitioners are not permitted to do so.

Mental health practitioners are advised to seek legal advice when they are unsure about particular issues and the legal/ethical ramifications of their actions.

14. CONTRACTOR'S SUBCONTRACT/CONSULTANT REQUIREMENTS: Contractor shall ensure that subcontractors and consultants providing services under this Agreement shall commence services within ninety (90) days of the execution of this Agreement. Subcontract and consultant agreements shall be signed and dated by the Contractor's Director, or his/her authorized designee(s) prior to commencement of

subcontracted and/or consultant services. (See ADDITIONAL PROVISIONS section for more detailed information).

15. REPORTS: Subject to the reporting requirements of the REPORTS Paragraph of the ADDITIONAL PROVISIONS of this Agreement attached hereto, Contractor shall submit the following report(s):

A. Monthly Reports: As directed by OAPP, Contractor shall submit a signed hard copy of the monthly report and, as requested, the electronic format of the report and the STANDARD CLIENT LEVEL REPORTING Data for Mental health, psychotherapy services no later than thirty (30) days after the end of each calendar month. The reports shall clearly reflect all required information as specified on the monthly report form and be transmitted, mailed, or delivered to Office of AIDS Programs and Policy, 600 South Commonwealth Avenue, 6th Floor, Los Angeles, California 90005, Attention: Financial Services Division.

B. Semi-Annual Reports: As directed by OAPP, Contractor shall submit a six (6) month summary of the data in hard copy, electronic, and/or online format for the periods January through June and July through December.

C. Annual Reports: As directed by OAPP, Contractor shall submit a summary of data in hard copy, electronic, and/or online format for the calendar year due by the end of February of the following year.

D. As directed by OAPP, Contractor shall submit other monthly, quarterly, semi-annual, and/or annual reports in hard copy, electronic, and/or online format

within the specified time period for each requested report. Reports shall include all the required information and be completed in the designated format.

16. COUNTY DATA MANAGEMENT SYSTEM: Contractor shall utilize County's data management system to register client's eligibility data, demographic/resource data, enter service utilization data, medical and support service outcomes, and to record linkages/referrals to other service providers and/or systems of care. County's system will be used to standardize reporting, importing efficiency of billing, support program evaluation process, and provide OAPP and participating contractors with information relative to the HIV/AIDS epidemic in Los Angeles County. Contractor shall ensure data quality and compliance with all data submission requirements.

17. ANNUAL TUBERCULOSIS SCREENING FOR STAFF: Prior to employment or provision of services, and annually thereafter, Contractor shall obtain and maintain documentation of tuberculosis screening for each employee, volunteer, and consultant providing services hereunder. Such tuberculosis screening shall consist of tuberculin skin test (Mantoux test) and/or written certification by a physician that the person is free from active tuberculosis based on a chest x-ray.

Contractor shall adhere to Exhibit D, "Guidelines for Staff Tuberculosis Screening", attached hereto and incorporated herein by reference. Director shall notify Contractor of any revision of these Guidelines, which shall become part of this Agreement.

18. EMERGENCY AND DISASTER PLAN: Contractor shall submit to OAPP within thirty (30) days of the execution of this Agreement an emergency and disaster

plan, describing the procedures and actions to be taken in the event of an emergency, disaster, or disturbance in order to safeguard Contractor's staff and recipients of services from Contractor. Situations to be addressed in the plan shall include emergency medical treatment for physical illness or injury of Contractor's staff and recipients of services from Contractor, earthquake, fire, flood, resident disturbance, and work action. Such plan shall include Contractor's specific procedures for providing this information to all program staff.

19. EMERGENCY MEDICAL TREATMENT: Clients receiving services hereunder who require emergency medical treatment for physical illness or injury shall be transported to an appropriate medical facility. The cost of such transportation as well as the cost of emergency medical care shall not be a charge to nor reimbursable hereunder. Contractor shall have a written policy(ies) for Contractor's staff regarding how to access Emergency Medical Treatment for recipients of services from the Contractor's staff. Copy(ies) of such written policy(ies) shall be sent to Los Angeles County Department of Public Health, Office of AIDS Programs and Policy, Clinical Enhancement Services Division.

20. PEOPLE WITH HIV/AIDS BILL OF RIGHTS AND RESPONSIBILITIES: Contractor shall adhere to all provisions within Exhibit H, People With HIV/AIDS Bill of Rights and Responsibilities (Bill of Rights) document attached hereto and incorporated herein by reference. Contractor shall post this document and/or Contractor-specific higher standard at all provider's delivery service sites, and disseminate it to all patients/clients. A Contractor-specific higher standard shall include, at a minimum, all

provisions within the Bill of Rights. In addition, Contractor shall notify and provide to its officers, employees, and agents, the Bill of Rights document and/or Contractor-specific higher standard.

If Contractor chooses to adapt this Bill of Rights document in accordance with Contractor's own document, Contractor shall demonstrate to OAPP, upon request, that Contractor fully incorporated the minimum conditions asserted in the Bill of Rights document.

21. QUALITY MANAGEMENT: Contractor shall implement a Quality Management (QM) program that assesses the extent to which HIV/AIDS services provided are consistent with federal (e.g., Public Health Services and CDC Guidelines), State, and local standards of HIV/AIDS care and/or prevention services. The QM program shall at a minimum:

A. Identify leadership and accountability of the medical director or executive director of the program;

B. Use measurable outcomes and data collected to determine progress toward established benchmarks and goals;

C. Focus on linkages to care and support services;

D. Track client perception of their health and effectiveness of the service received;

E. Serve as a continuous quality improvement (CQI) process reported to senior leadership annually.

22. QUALITY MANAGEMENT PLAN: Contractor shall develop program on a written QM plan. Contractor shall develop **one (1)** agency-wide QM plan that encompasses all HIV/AIDS care services. Contractor shall submit to OAPP within sixty (60) days of the receipt of this fully executed Agreement its written QM plan. The plan shall be reviewed and updated as needed by the agency's QM committee and signed by the medical director or executive director based on the agency's established internal policy and procedures but not less than three (3) years. The implementation of the QM plan will be reviewed by OAPP staff during the QM program review. The written QM plan shall at a minimum include the following eight (8) components.

A. Objectives: QM plan should delineate specific goals and objectives that reflect the program's mission, vision and values.

B. QM Committee: The plan shall describe the purpose of the Quality Management Committee, its composition (e.g., executive director, medical director, quality improvement manager/coordinator, program director, and program staff), meeting frequency, (quarterly, at minimum), and required documentation (e.g., minutes, agenda, sign-in sheet, etc.). Programs that already have an established advisory committee need not create a separate QM Committee, so long as the already existing advisory committee's composition and activities conform to QM program objectives.

C. Selection of a QM Approach: The QM plan shall describe an elected QM approach, such as Plan-Do-Study-Act (PDSA), Chronic Care Model or The Joint Commission Model, etc.

D. Implementation of QM Program:

(1) Measurement of Quality Indicators – agency shall collect and analyze data measured from specific OAPP selected indicators:

(a) Percent of clients reporting progress toward resolving the problems/concerns that caused them to seek or be referred to mental health psychotherapy services. (Goal - To be determined - Efficacy of Care)

(b) Percent of clients whose goals as described in the individualized treatment plan are achieved. (Goal - To be determined - Efficacy of Care)

(c) Percent of clients reporting an increased ability to adhere to their medical visits as a result of mental health psychotherapy services. (Goal - To be determined - Client Perspective Issue)

(d) Percent of clients reporting an increased ability to adhere to their HIV medications as a result of mental health psychotherapy services. (Goal - To be determined - Client Perspective Issue)

(e) Percent of clients who keep their mental health appointments. (Goal - To be determined - Efficacy of Care)

(f) Percent of clients who report adherence to their psychotropic medications. (Goal - To be determined - Efficacy of Care)

(g) Percent of clients who report satisfaction with the mental health services they receive. (Goal - To be determined - Client Perspective Issue)

In addition, the agency can measure other aspects of care and services as needed.

(2) Development of Data Collection Method – to include sampling strategy (e.g., frequency, percentage of sample sized), collection method (e.g., chart audits, interviews, surveys, etc.), and a data collection tool will be utilized for measuring aspects of care.

(3) Collection and Analysis of Data – analyzed results shall be reviewed and discussed by the QM committee. The findings of the data analysis shall be communicated with all program staff involved.

(4) Identification of Improvement Strategies – QM committee shall be responsible for identifying improvement strategies, tracking progress, and sustaining improvement.

E. Client Feedback Process: The QM plan shall describe the mechanism for obtaining ongoing feedback from clients regarding the accessibility and appropriateness of service and care. Feedback will also include the degree to which the service meets client needs and satisfaction. Client feedback shall be reviewed in the agency's QM Committee meetings on a regular basis for the enhancement of service delivery. Aggregate data is to be reported to the QM committee annually for continuous program improvement.

F. Client Grievance Process: Contractor shall establish policies and procedures for addressing and resolving client's grievances at the level closest to the source within agency. Grievance data is to be tracked, trended, and reported to the agency's QM committee for improvements of care and services at minimum quarterly. The information is to be made available to OAPP's staff during program review.

G. Incident Reporting: Contractor shall comply with incident and or sentinel event reporting as required by applicable federal and State laws, statutes, and regulations. Contractor shall furnish to OAPP Executive Office, upon the occurrence, during the operation of the facility, reports of incidents and/ or sentinel events specified as follows:

(1) A report shall be made to the appropriate licensing authority and to OAPP within the agency's next business day from the date of the event, pursuant to federal and State laws, statutes, and regulations. Events reported shall include the following:

(a) Any unusual incident and sentinel event which threatens the physical or emotional health or safety of any client to include, but not be limited to, client suicide, medication error, delay in treatment, and serious client fall;

(b) Any suspected physical or psychological abuse of any client, such as child, adult, and elderly.

(2) The written report shall contain the following information:

(a) Client's name, age, and sex;

(b) Date and nature of event;

(c) Disposition of the case;

(d) Staffing pattern at the time of the incident.

H. Random Chart Audits: Sampling criteria shall be based on important aspects of care and shall be, at a minimum, ten percent (10%) or thirty (30) charts, whichever is less. Results of chart audits will be reported and discussed in the QM committee quarterly.

23. QUALITY MANAGEMENT PROGRAM MONITORING: To determine the compliance level, OAPP shall review contractor's QM program annually. A numerical score will be issued to the contractor's QM program based on one hundred percent (100%) as the maximum score. Contractor's QM program shall be assessed for implementation of the following components:

A. Details of the QM plan (QM Objective, QM Committee, QM Approach Selection);

B. Implementation of QM Program;

C. Client Feedback Process;

D. Client Grievance Process;

E. Incident Reporting;

F. Random Chart Audit (if applicable).

24. CULTURAL COMPETENCY: Program staff should display non-judgmental, culture-affirming attitudes. Program staff should affirm that clients of ethnic and cultural

communities are accepted and valued. Programs are urged to participate in an annual self-assessment of their cultural proficiency.

**SCHEDULE «Schedules_number»,**

**«Agencys_NameCAPS»**

**HUMAN IMMUNODEFICIENCY VIRUS (HIV)**
**ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)**
**{ENTER SERVICE CATEGORY} SERVICES**

| | Budget Period<br>March 1, 2010<br>through<br>February 28, 2011 |
|---|---|
| Salaries | $ 0 |
| Employee Benefits | $ 0 |
| Travel | $ 0 |
| Equipment | $ 0 |
| Supplies | $ 0 |
| Other | $ 0 |
| Consultants/Subcontracts | $ 0 |
| Indirect Cost* | $ 0 |
| TOTAL PROGRAM BUDGET | $ 0 |

During the term of this Agreement, any variation to the above budget must have prior written approval of the Office of AIDS Programs and Policy's Director. Funds shall only be utilized for eligible program expenses. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets.

**SCHEDULE «Schedules_number»,**

**«Agencys_NameCAPS»**

**HUMAN IMMUNODEFICIENCY VIRUS (HIV)**
**ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)**
**{ENTER SERVICE CATEGORY} SERVICES**

| | Budget Period<br>March 1, 2011<br>through<br>February 28, 2012 |
|---|---|
| Salaries | $ 0 |
| Employee Benefits | $ 0 |
| Travel | $ 0 |
| Equipment | $ 0 |
| Supplies | $ 0 |
| Other | $ 0 |
| Consultants/Subcontracts | $ 0 |
| Indirect Cost* | $ 0 |
| TOTAL PROGRAM BUDGET | $ 0 |

During the term of this Agreement, any variation to the above budget must have prior written approval of the Office of AIDS Programs and Policy's Director. Funds shall only be utilized for eligible program expenses. Invoices and cost reports must be submitted and will be reimbursed in accordance with approved line-item detailed budgets.

Attachment 1

SERVICE DELIVERY SITE QUESTIONNAIRE

**SERVICE DELIVERY SITES**

**TABLE 1**

Site# 1 of 6

1 Agency Name: _____

2 Executive Director: _____

3 Address of Service Delivery Site: _____

_____

California

4 In which Service Planning Area is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Antelope Valley | _____ | Two: San Fernando Valley |
| _____ | Three: San Gabriel Valley | _____ | Four: Metro Los Angeles |
| _____ | Five: West Los Angeles | _____ | Six: South Los Angeles |
| _____ | Seven: East Los Angeles | _____ | Eight: South Bay |

5 In which Supervisorial District is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Supervisor Molina | _____ | Two: Supervisor Ridley-Thomas |
| _____ | Three: Supervisor Yaroslavsky | _____ | Four: Supervisor Knabe |
| _____ | Five: Supervisor Antonovich | | |

6 What percentage of your allocation is designated to this site? 0%

Attachment 1

SERVICE DELIVERY SITE QUESTIONNAIRE

**SERVICE DELIVERY SITES**

**TABLE 1**

Site# 2 of 6

1 Agency Name: _____

2 Executive Director: _____

3 Address of Service Delivery Site: _____

_____ California

4 In which Service Planning Area is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Antelope Valley | _____ | Two: San Fernando Valley |
| _____ | Three: San Gabriel Valley | _____ | Four: Metro Los Angeles |
| _____ | Five: West Los Angeles | _____ | Six: South Los Angeles |
| _____ | Seven: East Los Angeles | _____ | Eight: South Bay |

5 In which Supervisorial District is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Supervisor Molina | _____ | Two: Supervisor Ridley-Thomas |
| _____ | Three: Supervisor Yaroslavsky | _____ | Four: Supervisor Knabe |
| _____ | Five: Supervisor Antonovich | | |

6 What percentage of your allocation is designated to this site? 0%

Attachment 1

SERVICE DELIVERY SITE QUESTIONNAIRE

**SERVICE DELIVERY SITES**

**TABLE 1**

Site# 3 of 6

1 Agency Name: _____

2 Executive Director: _____

3 Address of Service Delivery Site: _____

_____ California

4 In which Service Planning Area is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Antelope Valley | _____ | Two: San Fernando Valley |
| _____ | Three: San Gabriel Valley | _____ | Four: Metro Los Angeles |
| _____ | Five: West Los Angeles | _____ | Six: South Los Angeles |
| _____ | Seven: East Los Angeles | _____ | Eight: South Bay |

5 In which Supervisorial District is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Supervisor Molina | _____ | Two: Supervisor Ridley-Thomas |
| _____ | Three: Supervisor Yaroslavsky | _____ | Four: Supervisor Knabe |
| _____ | Five: Supervisor Antonovich | | |

6 . What percentage of your allocation is designated to this site? 0%

Attachment 1

SERVICE DELIVERY SITE QUESTIONNAIRE

**SERVICE DELIVERY SITES**

**TABLE 1**

Site# 4 of 6

1 Agency Name: _____

2 Executive Director: _____

3 Address of Service Delivery Site: _____

California

4 In which Service Planning Area is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Antelope Valley | _____ | Two: San Fernando Valley |
| _____ | Three: San Gabriel Valley | _____ | Four: Metro Los Angeles |
| _____ | Five: West Los Angeles | _____ | Six: South Los Angeles |
| _____ | Seven: East Los Angeles | _____ | Eight: South Bay |

5 In which Supervisorial District is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Supervisor Molina | _____ | Two: Supervisor Ridley-Thomas |
| _____ | Three: Supervisor Yaroslavsky | _____ | Four: Supervisor Knabe |
| _____ | Five: Supervisor Antonovich | | |

6 What percentage of your allocation is designated to this site? 0%

Attachment 1

SERVICE DELIVERY SITE QUESTIONNAIRE

**SERVICE DELIVERY SITES**

**TABLE 1**

Site# 5 of 6

1 Agency Name: _____

2 Executive Director: _____

3 Address of Service Delivery Site: _____

California

4 In which Service Planning Area is the service delivery site?

| | |
|---|---|
| _____ One: Antelope Valley | _____ Two: San Fernando Valley |
| _____ Three: San Gabriel Valley | _____ Four: Metro Los Angeles |
| _____ Five: West Los Angeles | _____ Six: South Los Angeles |
| _____ Seven: East Los Angeles | _____ Eight: South Bay |

5 In which Supervisorial District is the service delivery site?

| | |
|---|---|
| _____ One: Supervisor Molina | _____ Two: Supervisor Ridley-Thomas |
| _____ Three: Supervisor Yaroslavsky | _____ Four: Supervisor Knabe |
| _____ Five: Supervisor Antonovich | |

6 What percentage of your allocation is designated to this site? 0%

Attachment 1

SERVICE DELIVERY SITE QUESTIONNAIRE

**SERVICE DELIVERY SITES**

**TABLE 1**

Site# 6 of 6

1 Agency Name: _____

2 Executive Director: _____

3 Address of Service Delivery Site: _____

California

4 In which Service Planning Area is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Antelope Valley | _____ | Two: San Fernando Valley |
| _____ | Three: San Gabriel Valley | _____ | Four: Metro Los Angeles |
| _____ | Five: West Los Angeles | _____ | Six: South Los Angeles |
| _____ | Seven: East Los Angeles | _____ | Eight: South Bay |

5 In which Supervisorial District is the service delivery site?

| | | | |
|---|---|---|---|
| _____ | One: Supervisor Molina | _____ | Two: Supervisor Ridley-Thomas |
| _____ | Three: Supervisor Yaroslavsky | _____ | Four: Supervisor Knabe |
| _____ | Five: Supervisor Antonovich | | |

6 What percentage of your allocation is designated to this site? 0%

SERVICE DELIVERY SITE QUESTIONNAIRE

## CONTRACT GOALS AND OBJECTIVES

## TABLE 2

Number of Mental Health Services - Psychotherapy Services Contract Goals and Objective by Service Delivery Site(s).
Please note: "No. of Clients" will refer to the number of **unduplicated** clients.

| Contract Goals and Objectives | Individual Psychotherapy | | Family/Conjoint Psychotherapy | | Group Psychotherapy | | Drop-In Psychoeducational Groups | |
|---|---|---|---|---|---|---|---|---|
| Service Unit | No. of Clients | No. of Hours | No. of Clients | No. of Hours | No. of Clients | No. of Hours | No. of Participants | No. of Hours |
| Site # 1 | | | | | | | | |
| Site # 2 | | | | | | | | |
| Site # 3 | | | | | | | | |
| Site # 4 | | | | | | | | |
| Site # 5 | | | | | | | | |
| Site # 6 | | | | | | | | |
| Site # 7 | | | | | | | | |
| Site # 8 | | | | | | | | |
| Site # 9 | | | | | | | | |
| Site # 10 | | | | | | | | |
| TOTAL | | | | | | | 0 | 0 |

**COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF AIDS PROGRAMS AND POLICY**
**HIV/AIDS RELATED SERVICES**

| Agency and Agreement Number | Baseline Year 19 Prior Allocation | Term 1 Year 20 Proposed Allocation | Term 2 Year 21 Proposed Allocation | Total Allocation (Term 1 + Term 2) | Service Planning Area | Supervisorial District | Performance as of September 30, 2008 Comments |
|---|---|---|---|---|---|---|---|
| **ADULT RESIDENTIAL FACILITY SERVICES - NCC** | | | | | | | |
| Term: 3/1/10 - 2/28/11 | | | | | | | |
| Project New Hope<br>H-700974 | $ 758,451 | $ 758,451 | | $ 758,451 | 4, 8 | 2 | Meeting Goals<br>Note: To be replaced by RFP #2010-03 |
| **Total** | **$ 758,451** | **$ 758,451** | **$ -** | **$ 758,451** | | | |
| **FOOD BANK/HOME DELIVERED MEALS/NUTRITIONAL SUPPLEMENTS SERVICES - PART A** | | | | | | | |
| Term1: 3/1/10 - 2/28/11 -- Term 2: 3/1/11 - 2/29/12 | | | | | | | |
| AIDS Project Los Angeles<br>H-700241 | $ 419,119 | $ 419,119 | $ 419,119 | $ 838,238 | 1-6, 8 | 1,5 | Meeting Goals |
| Bienestar Human Services, Inc.<br>H-700279 | $ 41,981 | $ 41,981 | $ 41,981 | $ 83,962 | 7 | 1 | Meeting Some Goals. Working with Agency to meet all goals. |
| Project Angel Food<br>H-700267 | $ 130,515 | $ 130,515 | $ 130,515 | $ 261,030 | 1-8 | 1-5 | Meeting Goals |
| **Total** | **$ 591,615** | **$ 591,615** | **$ 591,615** | **$ 1,183,230** | | | |
| **MENTAL HEALTH, PSYCHOTHERAPY - PART A** | | | | | | | |
| Term1: 3/1/10 - 2/28/11 -- Term 2: 3/1/11 - 2/29/12 | | | | | | | |
| AIDS Healthcare Foundation<br>H-210814 | $ 124,245 | $ 124,245 | $ 124,245 | $ 248,490 | 4,5,6 | 1,2,3,5 | Meeting Most Goals<br>Note: To be replaced by RFP #2010-xx |
| AIDS Project Los Angeles<br>H-210815 | $ 270,726 | $ 270,726 | $ 270,726 | $ 541,452 | 2-5, 7 | 4 | Meeting Most Goals<br>Note: To be replaced by RFP #2010-xx |
| AIDS Service Center<br>H-210792 | $ 168,389 | $ 168,389 | $ 168,389 | $ 336,778 | 3 | 4 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| AltaMed Health Services Corporation<br>H-210790 | $ 149,300 | $ 149,300 | $ 149,300 | $ 298,600 | 7 | 1 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| Bienestar Human Services, Inc.<br>H-210868 | $ 108,274 | $ 108,274 | $ 108,274 | $ 216,548 | 2,4 | 1,3 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Charles R. Drew University of Medicine & Science<br>H-210848 | $ 222,661 | $ 222,661 | $ 222,661 | $ 445,322 | 6 | 2 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Childrens Hospital Los Angeles<br>H-210842 | $ 29,214 | $ 29,214 | $ 29,214 | $ 58,428 | 4 | 3 | Meeting Most Goals<br>Note: To be replaced by RFP #2010-xx |
| Common Ground - The Westside HIV Community Center<br>H-210819 | $ 61,678 | $ 61,678 | $ 61,678 | $ 123,356 | 5 | 3 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| East Valley Community Health Center, Inc.<br>H-210817 | $ 43,522 | $ 43,522 | $ 43,522 | $ 87,044 | 3 | 1 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| The Los Angeles Gay and Lesbian Community Service Center<br>H-210803 | $ 105,473 | $ 105,473 | $ 105,473 | $ 210,946 | 3 | 4 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Minority AIDS Project<br>H-210836 | $ 55,623 | $ 55,623 | $ 55,623 | $ 111,246 | 6 | 2 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |

**COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF AIDS PROGRAMS AND POLICY**
**HIV/AIDS RELATED SERVICES**

| Agency and Agreement Number | Baseline Year 19 Prior Allocation | Term 1 Year 20 Proposed Allocation | Term 2 Year 21 Proposed Allocation | Total Allocation (Term 1 + Term 2) | Service Planning Area | Supervisorial District | Performance as of September 30, 2008 Comments |
|---|---|---|---|---|---|---|---|
| Northeast Valley Health Corporation<br>H-210823 | $ 92,049 | $ 92,049 | $ 92,049 | $ 184,098 | 2 | 3 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| South Bay Family Healthcare Center<br>H-210791 | $ 37,914 | $ 37,914 | $ 37,914 | $ 75,828 | 8 | 4 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Special Service for Groups<br>H-210818 | $ 91,630 | $ 91,630 | $ 91,630 | $ 183,260 | 4 | 1 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| St. Mary Medical Center<br>H-210847 | $ 108,000 | $ 108,000 | $ 108,000 | $ 216,000 | 8 | 4 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| Tarzana Treatment Center, Inc.<br>H-210794 | $ 97,861 | $ 97,861 | $ 97,861 | $ 195,722 | 2 | 3 | Meeting Most Goals<br>Note: To be replaced by RFP #2010-xx |
| Whittier Rio Hondo AIDS Project<br>H-300099 | $ 20,348 | $ 20,348 | $ 20,348 | $ 40,696 | 7 | 4 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Women Alive Coalition<br>H-210967 | $ 63,700 | $ 63,700 | $ 63,700 | $ 127,400 | 4 | 2 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| **Total** | **$ 1,850,607** | **$ 1,850,607** | **$ 1,850,607** | **$ 3,701,214** | | | |
| **ORAL HEALTH - PART A**<br>Term: 3/1/10 - 2/28/11 | | | | | | | |
| USC School of Dentistry<br>H-204756 | $ 175,060 | $ 399,072 | | $ 399,072 | 6 | 2 | Exceeding most Part A goals<br>Note: To be replaced by RFP #2010-xx |
| **Total** | **$ 175,060** | **$ 399,072** | **$ -** | **$ 399,072** | | | |
| **RESIDENTIAL CARE FACILITIES FOR THE CHRONICALLY ILL - NCC**<br>Term 3/1/10 - 2/28/11 | | | | | | | |
| Project New Hope<br>H-700964 | $ 920,685 | $ 920,685 | | $ 920,685 | 4 | 2 | Meeting Goals<br>Note: To be replaced by RFP #2010-03 |
| The Salvation Army<br>H-701033 | $ 848,896 | $ 848,896 | | $ 848,896 | 4 | 1 | Meeting Most Goals<br>Note: To be replaced by RFP #2010-03 |
| Serra Ancillary Care Corporation<br>H-700962 | $ 1,873,754 | $ 1,873,754 | | $ 1,873,754 | 4, 8 | 4 | Meeting Goals<br>Note: To be replaced by RFP #2010-03 |
| **Total** | **$ 3,643,335** | **$ 3,643,335** | **$ -** | **$ 3,643,335** | | | |
| **SUBSTANCE ABUSE - DAY TREATMENT - CSAT, THIRD DISTRICT FUNDS**<br>Term 1: 3/1/10 - 2/28/11 -- Term 2: 3/1/11 - 2/29/12 | | | | | | | |
| Cri-Help, Inc.<br>H-700976 | $ 21,880 | $ 21,880 | $ 21,880 | $ 43,760 | 2,4 | 3 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Substance Abuse Foundation<br>H-700977 | $ 17,286 | $ 17,286 | $ 17,286 | $ 34,572 | 4 | 1 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Van Ness Recovery House, Inc.<br>H-700965 | $ 28,401 | $ 186,734 | $ 28,401 | $ 215,135 | 4 | 1 | Exceeding Goals<br>Note: To be replaced by RFP #2010-xx |
| **Total** | $ 67,567 | **$ 225,900** | **$ 67,567** | $ 293,467 | | | |

**COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF AIDS PROGRAMS AND POLICY**
**HIV/AIDS RELATED SERVICES**

| Agency and Agreement Number | Baseline Year 19 Prior Allocation | Term 1 Year 20 Proposed Allocation | Term 2 Year 21 Proposed Allocation | Total Allocation (Term 1 + Term 2) | Service Planning Area | Supervisorial District | Performance as of September 30, 2008 Comments |
|---|---|---|---|---|---|---|---|
| **SUBSTANCE ABUSE - RESIDENTIAL REHABILITATION - PART A, SAM CARE, & CSAT** | | | | | | | |
| Term 1: 3/1/10 - 2/28/11 -- Term 2: 3/1/11 - 2/29/12 | | | | | | | |
| Behavioral Health Services<br>H-700970 | $ 129,569 | $ 129,569 | $ 129,569 | $ 259,138 | 2 | 3 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| Cri-Help, Inc.<br>H-700987 | $ 204,222 | $ 204,222 | $ 204,222 | $ 408,444 | 2,4 | 1,3 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Los Angeles Center for Alcohol & Drug Abuse<br>H-700971 | $ 132,892 | $ 132,892 | $ 132,892 | $ 265,784 | 7 | 1 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| Prototypes - A Center for Innovation in Health, Mental Health & Social Services<br>H-700985 | $ 117,892 | $ 117,892 | $ 117,892 | $ 235,784 | 5 | 3 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| Rainbow Bridge Community Services<br>H-700980 | $ 144,914 | $ 144,914 | $ 144,914 | $ 289,828 | 4 | 1 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Substance Abuse Foundation<br>H-700961 | $ 224,725 | $ 224,725 | $ 224,725 | $ 449,450 | 8 | 4 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Tarzana Treatment Center<br>H-700982 | $ 353,054 | $ 353,054 | $ 353,054 | $ 706,108 | 2 | 3 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Van Ness Recovery House, Inc.<br>H-700978 | $ 197,797 | $ 197,797 | $ 197,797 | $ 395,594<br>$ - | 2 | 3 | Meeting Goals<br>Note: To be replaced by RFP #2010-xx |
| Watts Healthcare Corporation<br>H-701059 | $ 206,648 | $ 206,648 | $ 206,648 | $ 413,296 | 2 | 3 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| **Total** | **$ 1,711,713** | **$ 1,711,713** | **$ 1,711,713** | **$ 3,423,426** | | | |
| **SUBSTANCE ABUSE - RESIDENTIAL DETOXIFICATION - PART A, SAM CARE, CSAT** | | | | | | | |
| Term 1: 3/1/10 - 2/28/11 -- Term 2: 3/1/11 - 2/29/12 | | | | | | | |
| Behavioral Health Services<br>H-700986 | $ 86,206 | $ 86,206 | $ 86,206 | $ 172,412 | 8 | 4 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| Cri-Help, Inc.<br>H-700975 | $ 132,625 | $ 132,625 | $ 132,625 | $ 265,250 | 2 | 3 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| Tarzana Treatment Center<br>H-700983 | $ 323,036 | $ 323,036 | $ 323,036 | $ 646,072 | 2 | 3 | Meeting Some Goals. Working with Agency to meet all goals.<br>Note: To be replaced by RFP #2010-xx |
| **Total** | **$ 541,867** | **$ 541,867** | **$ 541,867** | **$ 1,083,734** | | | |

**COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH**
**OFFICE OF AIDS PROGRAMS AND POLICY**
**HIV/AIDS RELATED SERVICES**

| Agency and Agreement Number | Baseline Year 19 Prior Allocation | Term 1 Year 20 Proposed Allocation | Term 2 Year 21 Proposed Allocation | Total Allocation (Term 1 + Term 2) | Service Planning Area | Supervisorial District | Performance as of September 30, 2008 Comments |
|---|---|---|---|---|---|---|---|
| **SUBSTANCE ABUSE - TRANSITIONAL HOUSING - PART A, SAM CARE, THIRD DISTRICT FUNDS** | | | | | | | |
| Term 1: 3/1/10 - 2/28/11 -- Term 2: 3/1/11 - 2/29/12 | | | | | | | |
| Rainbow Bridge Community Services | $ 58,794 | $ 248,864 | $ 58,794 | $ 307,658 | 4 | 1 | Meeting Goals |
| H-701005 | | | | | | | |
| | | | | | | | Note: To be replaced by RFP #2010-xx |
| Substance Abuse Foundation | $ 142,951 | $ 142,951 | $ 142,951 | $ 285,902 | 8 | 4 | Meeting Some Goals. Working with Agency to meet all goals. |
| H700973 | | | | | | | |
| | | | | | | | Note: To be replaced by RFP #2010-xx |
| Tarzana Treatment Center | $ 90,526 | $ 217,122 | $ 90,526 | $ 307,648 | 2 | 3 | Meeting Goals |
| H-701004 | | | | | | | |
| | | | | | | | Note: To be replaced by RFP #2010-xx |
| **Total** | **$ 292,271** | **$ 608,937** | **$ 292,271** | **$ 901,208** | | | |
| **GRAND TOTAL** | **$ 9,632,486** | **$ 10,331,497** | **$ 5,055,640** | **$ 15,387,137** | | | |

| | Year 20 Summary | Year 21 Summary | Total Summary |
|---|---|---|---|
| Part A | $ 4,199,340 | $ 3,800,268 | $ 7,999,608 |
| CSAT | $ 488,756 | $ 488,756 | $ 977,512 |
| NCC | $ 4,401,786 | $ - | $ 4,401,786 |
| SAM Care | $ 766,616 | $ 766,616 | $ 1,533,232 |
| 3rd District Funds | $ 474,999 | $ - | $ 474,999 |
| TOTAL | $ 10,331,497 | $ 5,055,640 | $ 15,387,137 |

| |
|---|
| Year 20 Total |
| 3/1/10 - 2/28/11 |
| $10,331,497 |
| Year 21 Total |
| 3/1/11 - 2/29/12 |
| $5,055,640 |
| Maximum Total |
| 3/1/10 - 2/29/12 |
| $ 15,387,137 |